STATE OF CONNECTICUT

OFFICE OF PROTECTION AND ADVOCACY FOR
PERSONS WITH DISABILITIES
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Testimony of the Office of Protection and Advocacy for Persons with Disabilities
Before the Judiciary Committee

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March 24, 2009

Good afternoon and thank you for this opportunity to comment on several of the bills on your agenda today.

Raised Bill No. 348, An Act Concerning the Videotaping of Custodial Interrogations establishes a rebuttable presumption of inadmissibility of a statement (e.g. confession) obtained from a person suspected of committing a serious crime when that statement was obtained during a custodial interrogation and no recording is made of the interrogation. By operation of the definitions and explicit exceptions listed in the bill, the presumption of inadmissibility would be strictly limited, and could be overcome in a number of circumstances.

Our Office supports this proposal. The video recordings called for in this bill would help safeguard the rights of people with cognitive or psychiatric disabilities who may be subject to interrogations. Many people who have mental retardation, non-verbal learning disabilities, autism-spectrum disabilities, brain injuries and mental illnesses find themselves at a significant disadvantage when being questioned by authorities. Although generalizing is risky and often unfair, there is strong evidence to the effect that people with mental disabilities are often more easily talked into agreeing to do or say things. Some of this is a survival strategy: people who have intellectual disabilities or who experience difficulty reading social cues often cultivate a sense of how to please authority figures and "pass" in situations where they do not fully understand what is happening. In the context of custodial interrogation, relying on such a strategy can prove disastrous. But there is more involved than a desire to pass for "normal" and to please others. Some of the problem also has to do with naiveté and confusion: if you have a mental disability, it is easy to become confused or insecure as to your own recollections of past events, and you are quite likely to accept interpretations offered by others.

Unfortunately, interrogation techniques designed to undermine the resistance of "typical" suspects can so confuse people with mental disabilities that they may falsely confess, perhaps even without recognizing that they have done so. Across the country evidence is mounting that people with mental disabilities are particularly susceptible to falsely confessing when confronted by exhausting, aggressive interrogation tactics. Various

studies and investigations into the phenomenon of "false confession" point to a high correlation between mental disability and susceptibility to faulty results from intensive interrogation techniques.

The fact that a person has a cognitive or psychiatric disability is often not immediately apparent to interrogators. When a question of cognitive or psychological function is subsequently raised, having a recording to refer to will likely be very helpful in determining the reliability of the person's statements and the circumstances under which they were obtained. Knowing what was actually said would also go a long way toward preventing wrongful convictions, and assuring that our criminal justice system treats persons with cognitive and psychiatric disabilities fairly. Our Office urges your support for this legislation.

Our Office also supports **Raised Bill No. 6533, An Act Concerning a Department of Correction Advisory Commission.** As the title implies, this proposal would establish an Advisory Commission to review Department of Correction (DOC) policies and practices, and to recommend changes. While the proposed commission would not have direct authority over any aspect of DOC operations, it would help ensure that the State's commitment to progressive corrections policy continues over the long term.

As the Committee is aware, increasing numbers of people with psychiatric disabilities have been incarcerated in recent years. Nationally, it is now estimated that over 20% of all prison inmates have a mental illness serious enough to require treatment and Connecticut estimates are similar. Many factors contribute to this unfortunate trend, but whatever its origins, it has tremendous implications for prison management, mental health care requirements, educational and rehabilitation programming, disciplinary practices and overall human rights. Considering that the correctional system also houses people with cognitive and intellectual disabilities, communications and sensory disabilities, and physical disabilities, it is heartening to note that our Office has been included on the membership of the commission.

Our Office also supports **Raised Bill No. 537, An Act Providing Community Reintegration Services to End of Sentence Inmates.** This bill would require that inmates who "max out" in prison be offered the same transitional support services currently provided to those inmates who are released on parole or under other supervised release mechanisms. As referred to above, a significant number of the people we are sending to prison have psychiatric, intellectual and cognitive disabilities. While DOC has been working with its community providers to ensure that they are not discriminating against people with those types of disabilities, and DMHAS has shown genuine interest in collaborative transitional programs, in our Office's experience, it is still more likely that an inmate with psychiatric, developmental or cognitive disabilities will "max out" in institutional lock up than will other, non-disabled inmates who have been convicted of similar crimes and who present similar risk profiles. To the extent that this bill would

enhance the availability of transition planning and coordination with social service agencies, it would both benefit those individuals and help reduce recidivism.

Thank you for your attention. If there are any questions, I will try to answer them.

How many? According to statistics provided to advocates by the Department of Correction, on a typical day last summer, 3,897 of approximately 19,000 inmates committed to DOC custody (sentenced and unsentenced) were classified as either MH3, MH4, or MH5. Of these, 1,741 (46%) were either being held on low bonds or had been sentenced following conviction for the types of crimes that are considered to be non-violent and non-serious. (DOC makes these determinations as part of its security risk screening process.) While this data represents a "snap-shot" only, it strongly suggests that as many as 1,500 – 1,800 prison beds could be freed up if community-based support and supervision programs were adequately resourced.

As I testified at the hearing, advocates are quite concerned that building a hospital prison facility for inmates with mental illness will displace resources that could be better used to improve community support programs. Constructing a new facility could create the impression that there was a "good place" for people with psychiatric and other mental disabilities in the correction system a perception that could ultimately result in even more people with mental disabilities being sent to jail. It is worth noting that the vast majority of inmates with identified mental health needs are classified at the MH 3 level (3,368 out of 3,897). Although this category includes individuals with psychiatric histories (e.g., diagnoses of schizophrenia, major depression, bi-polar disorders, etc.), and many of them take psychotropic medications and/or receive other forms of treatment, these individuals are seen as sufficiently stable to be housed in the general population. This is not to say that developing a health care – oriented facility would not be justified for purposes such as providing enhanced nursing and physical care for individuals who are aging, have significant physical disabilities or debilitating illnesses, etc. However, given the scarcity of community-based support options, building a prison facility focused on mental health treatment will likely exacerbate rather than relieve the factors underlying the current trend toward criminalizing mental illness.

Until DOC develops a discrete statistical subcategory for "mental retardation", we will not know how many inmates meet the criteria for that label. Researchers estimate that anywhere from 2% to 10% of the U.S. prison population could be diagnosed as having mental retardation. However, the number of individuals who were identified as having a specific intellectual or cognitive disability prior to their incarceration is probably on the lower end of this range (e.g., 3-4%). While fewer inmates have intellectual disabilities than psychiatric disabilities, our Office's case experience indicates that at least some of these people would not have been incarcerated if appropriate services and supports had been made available. Investing in a genuine jail diversion program for people with developmental disabilities, and providing the Department of Developmental Disabilities with resources and a specific mandate to support people with developmental disabilities who are eligible for probation and parole, could help reduce prison overcrowding and improve public safety while advancing the interests of justice.